Prior Authorization Policy

Prior Authorization/Precertification is the process of collecting information before inpatient admissions and select ambulatory procedures and services for review and determination of coverage.

POLICY

- In network practitioners and providers may be required to obtain prior authorization from the health plan before providing certain services or procedures,
    - non-emergent hospitalizations
    - elective hospitalizations,
    - facility placement (e.g., nursing facility).
    - Outpatient requests/Ambulatory care
- In network practitioners making referrals to out of network providers may require prior authorization.
- Any variance from the health plan's prior authorization policies and procedures may result in denial or delay of reimbursement.
- Medicaid members may not be billed directly for covered, non-authorized services which have been provided.

Services Requiring Authorization

The health plan Provider Manual, and when applicable the health plan website, lists the services that require prior authorization

- consistent with the health plan's policies and governing regulations.
- The list is updated at least annually and revised periodically as appropriate.
- It is available to members, practitioners, providers, and internal staff either in the
    - Member Handbook,
    - Provider Manual,
    - the website,
    - the Medicaid Web Portal for members,
    - the Provider Portal or by request from the Provider Services or
    - by contacting the Member Services departments.

Exceptions to Service Authorizations

The following services do not require authorization, whether furnished by a network or non-network provider or practitioner:

- Family planning services
- Well-woman services
- Admission for normal labor and delivery

Emergency Services

Emergency services do not require prior authorization.

Requirements for Initiating a Request for Authorization

Generally, a member's Primary Care Physician or treating practitioner/provider is responsible for initiating and coordinating a request for authorization.

The requesting practitioner or provider is responsible for

- Complying with the health plan's prior authorization requirements, policies, and request procedures
- Obtaining an authorization number to facilitate reimbursement of claims.
- Members may initiate a request for a coverage of services or supplies.
- When the health plan staff receives the request, the member is offered a warm transfer to the prior authorization team for authorization initiation.
- If the member declines the transfer, the staff obtains as much information as possible including
    - The name of practitioner/provider performing or recommending the service.
    - The information is then provided to the prior authorization team for initiation of the authorization.
    - The prior authorization team obtains any additional clinical information necessary to complete the request**.**
    - Under no circumstances is the member instructed to contact the practitioner/provider to initiate or complete the request. A
- All requests for authorization follow applicable federal or health plan controlling state timeframes.

Information Required for a Review

A prior authorization request must include the following:

- Current, applicable codes which may include:
    - Current Procedural Terminology (CPT)
    - International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)
    - Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes
    - National Drug Code (NDC)
- Name, date of birth, gender, and identification number of the member
- PCP or treating practitioner/provider
- Name, address, phone and fax number and signature, if applicable, of the referring practitioner or provider
- Name, address, phone and fax number of the consulting practitioner or provider
- Reason for the request
- Presentation of supporting objective clinical information, such as clinical notes, comorbidities, complications, progress of treatment, psychosocial situation, home environment, laboratory and imaging studies, and treatment dates, as applicable for the request

All necessary clinical information must be submitted with the original request.

Medical Necessity Criteria (Physical and Behavioral Health)

To support prior authorization decisions, the health plan uses nationally recognized and/or evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Individual characteristics of the member to be considered may include the following when applying criteria:

- Age,
- Comorbidities,
- Medical complications,
- Progress of treatment,
- Psychosocial situation and
- Home environment, when applicable.

Service authorization staff that make medical necessity determinations are trained on the criteria and the criteria is established and reviewed according to the health plan policies and procedures.

Medical necessity criteria are available upon request.

Prior Authorization Period of Validation

- A prior authorization number is valid for the date of service authorized or for a period not to exceed six (6) months after the health care provider receives the prior authorization approval or, the length of treatment as determined by the patient's health care professional or the renewal of the plan.
- A prior authorization number is valid for twelve (12) months for treatment of chronic or long-term conditions after the health care provider receives the prior authorization approval.

Termination, Suspension, or Reduction of Services

The health plan gives at least ten (10) calendar days' notice before the date of action whenever the action is termination, suspension, or reduction of previously authorized services.

Post Service (Retrospective) Review

When making post-service reviews, the health plan bases reviews solely on the medical information available to the attending physician or ordering practitioner/provider at the time the health care services were provided. Post-service determinations are reviewed against the same criteria used for pre-service determinations for the same service.

School Based Services:

The health plan shall offer contracts to all the school health centers recognized by the Department of Public Health that are in the contracting area and shall not require prior authorization or a referral as a condition of payment for school-based health center services provided by those school-based health centers with which the health plan has contracts.

Review/Revision History

Policy effective date	12/01/2020
Reviewed	08/2025